Five things you can do to make Person-Centered Support Plans *more* person-centered!

1. **Supports Intensity Scale.** When completing the Supports Intensity Scale and marking items "important TO the person," make sure to reflect passions, interests, what is most important to the person in their life, and address quality of life issues. Add notes explaining exactly what it is that makes it so important, not just a general category. Avoid most health and safety issues (mark those as "important FOR the person) and ask: "If you were healthy and safe, what would you want to do?" "How would your life be different if you were healthy?

SIS
Important **TO:____**

PCSP

2. PCSP Coversheet. Set the tone (emotional response of the reader) by adding something on the front cover that says: "This is a plan about a person!" – not a client, consumer, person with a disability." This could be photo, drawing, song, quote, handprint, anything you can get an electronic copy of and place in the Word document. Does a piece of paper with the person's name, a date, and the words "Person-Centered Service Plan" best communicate what you want the reader to see first? Most families and service provider direct staff would be willing to come up with something.

3. **Person-Centered Profile.** Include important information about the person. It can include information from all those who know and support the person, but it needs to be information you want others to know about the person and what is important to the person. It should highlight the most important information, not just a large amount!

P-C Profile
Likes:
Friends:

4. **Personal Goals.** Make sure these are based on issues identified as "most important to the person" and make sure they are real! These need to be things the Team agrees to support the person to accomplish and will make a notable difference in the person's life. Use "Short-term Goals" if needed to focus on something doable but still important by itself. Avoid goals that are just dreams and avoid short-term goals that are just prerequisites or "get ready" to do something important. Remember we believe the best way to address needs efficiently and effectively is by trying to provide the person with the life they want!

GOALS
I will…

5. **Non-goal related supports.** Add non-goal related supports related to the "TO" list – quality of life issues we can address and make a difference in the person's life now! This can be anything; do not limit this to traditional supports. If something will make a big difference in the person's life, you might want to include it in the plan. Examples: call mother once a day, paint bed room red, go to church every week, go camping, find a new doctor, buy a new TV, make a new friend, get a pet… *you get the idea!* These could be one-time, time-limited, or ongoing supports; they could be something someone else does for the person or something that is taught to the person.

Additional Supports:
1.
2.
3.

Alan Tribble, March 2008

Person-Centered Planning as a Set of Promises

A Promise –

To Listen
- To what is important TO the person
- To what is important FOR the person

To Act on what is learned
- To help the person get more of what is most important TO them
- To get a better balance between TO and FOR

To be honest about what we can't do right now

To never stop trying

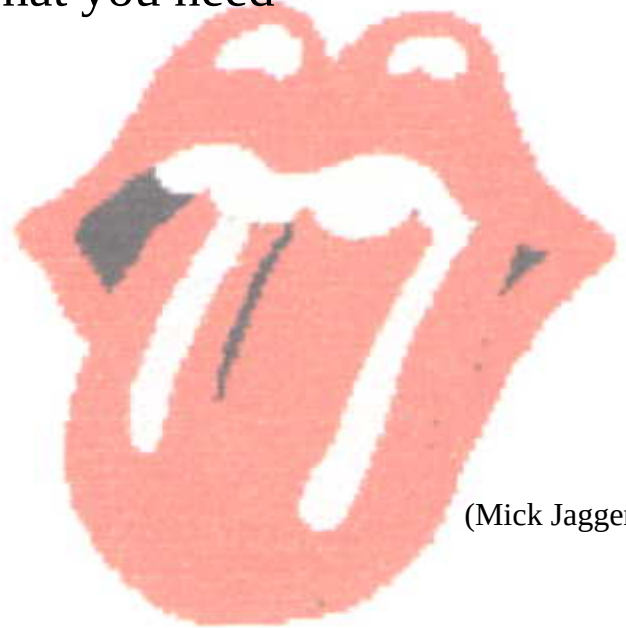
(Smull, 2002)

We believe the <u>best</u> way to address needs efficiently and effectively is by trying to provide the person with the life they want.

(DSPD, 2008)

YOU CAN'T ALWAYS GET WHAT YOU WANT

You can't always get what you want
But if you try sometimes, well you might find
You get what you need



(Mick Jagger and Keith Richards, 1968)